

**Payment Verification Worksheet** for Patient \_\_\_\_\_ Date \_\_\_\_\_

Primary insurance Name \_\_\_\_\_ Phone Number (      ) \_\_\_\_\_

Address to send claims: \_\_\_\_\_

<b>PRI</b>	Date of Eligibility	Copay \$	Deductible \$	Met \$	Coinsurance %	Maximums?	Notes:
	<b>WC</b>	Employer Phone	Company Name		Employer Address		Contact Person
		Claim Number	Adjuster Name		Phone #		Date of Injury
	Date of Auth.	# Visits	Exp. Date	Auth #		Person Auth	
<b>Lien</b>	Attorney Name	Phone #		Address			Date of Accident
<b>Auto</b>	Third Party Name			Insurance Name		Phone #	Claim #
<b>Self</b>	<input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Amer Ex	Name on Card		Card #		Exp Date	3 digit code (on back)
	Date of Verification	Staff Name		Comments:			